

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042424</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Maple Lawn Health Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2000</u> to <u>12/31/2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>700 North Main</u> <u>Eureka</u> <u>61530</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Woodford</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(309) 467-2337</u> Fax # <u>(309) 467-9097</u>		(Type or Print Name) _____	
IDPA ID Number: <u>370681536001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>1922</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u>	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
IRS Exemption Code <u>501(C)3</u>		SEE ACCOUNTANTS' COMPILATION REPORT	
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Michael G. Kaplan</u> Telephone Number: <u>(312) 634-3400</u>			
<u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u>			

Please send copies of any desk review or audit adjustments to the above address

STATE OF ILLINOIS

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Facility Name & ID Number Maple Lawn Health Center# 0042424 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>89</u>	Skilled (SNF)	<u>89</u>	<u>32,574</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>29</u>	Sheltered Care (SC)	<u>29</u>	<u>10,614</u>	5
6		ICF/DD 16 or Less			6
7	<u>118</u>	TOTALS	<u>118</u>	<u>43,188</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,249</u>	<u>11,459</u>	<u>1,287</u>	<u>17,995</u>	8
9	SNF/PED					9
10	ICF	<u>7,204</u>	<u>6,708</u>		<u>13,912</u>	10
11	ICF/DD					11
12	SC	<u>1,656</u>	<u>8,724</u>		<u>10,380</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,109</u>	<u>26,891</u>	<u>1,287</u>	<u>42,287</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.91%

D. How many bed-hold days during this year were paid by Public Aid?

39 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐ Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1922

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 13 and days of care provided 1,287Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	232,851	15,445	11,658	259,954		259,954	(119)	259,835			1
2	Food Purchase		273,035		273,035		273,035	(65,070)	207,965			2
3	Housekeeping	112,580	22,245	383	135,208		135,208		135,208			3
4	Laundry	55,816	8,726		64,542		64,542		64,542			4
5	Heat and Other Utilities			118,062	118,062		118,062	(2,964)	115,098			5
6	Maintenance	72,893	5,182	86,783	164,858		164,858	(42,665)	122,193			6
7	Other (specify):*											7
8	TOTAL General Services	474,140	324,633	216,886	1,015,659		1,015,659	(110,818)	904,841			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	1,702,870	116,406	77,236	1,896,512		1,896,512		1,896,512			10
10a	Therapy		620	139,990	140,610		140,610		140,610			10a
11	Activities	83,955	6,970	1,058	91,983		91,983		91,983			11
12	Social Services	55,519	1,102	765	57,386		57,386		57,386			12
13	Nurse Aide Training	16,221	1,829	1,505	19,555		19,555		19,555			13
14	Program Transportation			4,642	4,642		4,642		4,642			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,858,565	126,927	226,996	2,212,488		2,212,488		2,212,488			16
	C. General Administration											
17	Administrative	54,189		128,112	182,301		182,301	(128,112)	54,189			17
18	Directors Fees											18
19	Professional Services			19,678	19,678		19,678	12,644	32,322			19
20	Dues, Fees, Subscriptions & Promotions			20,526	20,526		20,526	862	21,388			20
21	Clerical & General Office Expenses	277,084	7,686	57,266	342,036		342,036	46,376	388,412			21
22	Employee Benefits & Payroll Taxes			467,916	467,916		467,916	71,197	539,113			22
23	Inservice Training & Education			1,320	1,320		1,320		1,320			23
24	Travel and Seminar			13,168	13,168		13,168	4,513	17,681			24
25	Other Admin. Staff Transportation			383	383		383	3,776	4,159			25
26	Insurance-Prop.Liab.Malpractice			23,338	23,338		23,338	2,161	25,499			26
27	Other (specify):*											27
28	TOTAL General Administration	331,273	7,686	731,707	1,070,666		1,070,666	13,417	1,084,083			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,663,978	459,246	1,175,589	4,298,813		4,298,813	(97,401)	4,201,412			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			156,561	156,561		156,561	35,828	192,389			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,111	98,111		98,111	(48,953)	49,158			32
33	Real Estate Taxes			2,700	2,700		2,700	(2,700)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			257,372	257,372		257,372	(15,825)	241,547			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,229	3,524	25,753		25,753		25,753			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,862	48,862		48,862		48,862			42
43	Other (specify):* Nonallowable costs			74,797	74,797		74,797	(74,797)				43
44	TOTAL Special Cost Centers		22,229	127,183	149,412		149,412	(74,797)	74,615			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,663,978	481,475	1,560,144	4,705,597		4,705,597	(188,023)	4,517,574			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(65,070)	2		4
5 Telephone, TV & Radio in Resident Rooms	(6,566)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(692)	30		9
10 Interest and Other Investment Income	(49,664)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(528)	20		17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(9,750)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See attached Schedule 5A	(73,452)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (205,722)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	17,699		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 17,699		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (188,023)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1		1
2		2
3		3
4		4
5		5
6		6
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10		10
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84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/2000Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Maple Lawn Health Center, Inc.	100.00%			Maple Lawn Homes	Eureka	Ret. House Mgmt
				Maple Lawn Apart.	Eureka	Ret. Housing
				Maple Lawn Cottages	Eureka	Ret. Housing
				Maple Lawn	Eureka	Home Care
				Living Care		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$ 7,800	Maple Lawn Homes	0.00%	\$ 4,836	\$ (2,964)	1
2	V	6 Maintenance Expense	50,304	Maple Lawn Homes	0.00%	7,639	(42,665)	2
3	V	17 Administrative Service Fees	128,112	Maple Lawn Homes	0.00%		(128,112)	3
4	V	19 Professional Services		Maple Lawn Homes	0.00%	12,644	12,644	4
5	V	20 Fees, Subscriptions & Promotions		Maple Lawn Homes	0.00%	1,390	1,390	5
6	V	21 Clerical & General Office Exp.		Maple Lawn Homes	0.00%	53,927	53,927	6
7	V	22 Employee Benefits		Maple Lawn Homes	0.00%	71,197	71,197	7
8	V	24 Travel & Seminar		Maple Lawn Homes	0.00%	7,679	7,679	8
9	V	25 Other Admin. Staff Transportation		Maple Lawn Homes	0.00%	3,776	3,776	9
10	V	26 Insurance- Prop. Liab. Malpractice		Maple Lawn Homes	0.00%	2,161	2,161	10
11	V	30 Depreciation		Maple Lawn Homes	0.00%	36,520	36,520	11
12	V	32 Interest		Maple Lawn Homes	0.00%	711	711	12
13	V	33 Real Estate Taxes		Maple Lawn Homes	0.00%	1,435	1,435	13
14	Total		\$ 186,216			\$ 203,915	\$ * 17,699	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5	N/A										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/2000

Ending:

12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Maple Lawn HomesStreet Address 700 North MainCity / State / Zip Code Eureka, IL 61530Phone Number (309) 467-2337Fax Number (309) 467-9097

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost	7,029,172	2	\$ 8,214	\$ 4,138,372	\$ 4,836	1
2	6	Maintenance Expense	Time Study	14,730	2	22,220	5,064	7,639	2
3	19	Professional Services	Accumulated Cost	7,029,172	2	17,941	4,138,372	10,563	3
4	19	Professional Services	Salary Allocation	708,912	2	4,595	321,022	2,081	4
5	20	Fees, Subscriptions & Promotions	Accumulated Cost	7,029,172	2	2,296	4,138,372	1,352	5
6	20	Fees, Subscriptions & Promotions	Salary Allocation	708,912	2	84	321,022	38	6
7	21	Clerical & General Office Exp.	Accumulated Cost	7,029,172	2	91,416	4,138,372	53,820	7
8	21	Clerical & General Office Exp.	Time Study	14,730	2	312	5,064	107	8
9	22	Employee Benefits	Accumulated Cost	7,029,172	2	2,669	4,138,372	1,571	9
10	22	Employee Benefits	Salary Allocation	708,912	2	153,756	321,022	69,626	10
11	24	Travel & Seminar	Accumulated Cost	7,029,172	2	13,043	4,138,372	7,679	11
12	25	Other Admin. Staff Transportation	Accumulated Cost	7,029,172	2	6,413	4,138,372	3,776	12
13	26	Insurance-Prop. Liab. Malpractice	Accumulated Cost	7,029,172	2	3,670	4,138,372	2,161	13
14	30	Depreciation	Accumulated Cost	7,029,172	2	62,031	4,138,372	36,520	14
15	32	Interest	Accumulated Cost	7,029,172	2	1,207	4,138,372	711	15
16	33	Real Estate	Accumulated Cost	7,029,172	2	2,437	4,138,372	1,435	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 392,304	\$	\$ 203,915	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center # 0042424 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	FHA Mortgage # 1		x	Building	\$4,663.00	04/04/79	\$ 860,000	\$ 432,089	04/04/11	0.0500	\$ 22,426	1	
2	FHA Mortgage # 2		x	Building	\$6,300.00	07/07/89	900,000	679,701	07/07/14	0.0650	45,161	2	
3	FHA Mortgage # 3		x	Building	\$665.00	07/07/89	90,000	69,170	07/07/14	0.0713	5,033	3	
4	City of Eureka Bonds		x	Building	\$3,465.00	07/07/89	455,000	346,367	07/07/12	0.0765	25,491	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$15,093.00		\$ 2,305,000	\$ 1,527,327			\$ 98,111	9	
	B. Non-Facility Related*												
10	Interest Income										(49,664)	10	
11	Allocation from Management Company										711	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (48,953)	14	
15	TOTALS (line 9+line14)						\$ 2,305,000	\$ 1,527,327			\$ 49,158	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Maple Lawn Health Center**# **0042424** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	2,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2,442	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(258)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	2,958	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		(4,135)	
TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	-	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	2,099	8
	1996	2,208	9
	1997	2,507	10
	1998	2,534	11
	1999	2,442	12

1999 Real Estate Tax Bill	2442		
Est. Increase	516	While this entity is a 501(C)3 not-for-profit organization, it is paying real	
Est. 2000 Tax	2958	estate taxes for a portion of the facility that is deemed nonexempt.	

	FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

42,837

B. General Construction Type:

Exterior

Brick

Frame

Brick, Mortar, Steel

Number of Stories

2

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

Maple Lawn Homes - Retirement Housing Management

Maple Lawn Apartments - Retirement Housing

100 Apartments

Maple Lawn Cottages - Retirement Housing

84 Cottages

Maple Lawn Living Care - Home Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Health Center	85,000	1965	\$ 1,386	1
2	Health Center	39,000	1969	1,000	2
3	TOTALS	124,000		\$ 2,386	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1965	1965	\$ 472,000	\$ 7,867	60	\$ 7,867		\$ 282,546	4
5			1974	1974	20,378	408	50	408		10,754	5
6			1980	1980	750,017	16,667	45	16,667		348,280	6
7			1982	1982	7,703	385	20	385		7,031	7
8	38		1989	1989	1,459,363	32,430	45	32,430		372,947	8
	Improvement Type**										
9	COURTYARD - disposed during year										
10	TREES										
11	LANDSCAPING										
12	TREES										
13	TREES										
14	ROSE GARDEN										
15	LANDSCAPING - disposed during year										
16	PARKING BASE										
17	LANDSCAPING										
18	ASPHALT REPAIR										
19	PARKING LOT LIGHTING										
20	ASPHALT PARKING LOT										
21	ADU ENCLOSURE										
22	PARKING BLOCKS (23)										
23	RESHINGLE BARN - disposed during year										
24	UPPER LOBBY RENOVATION										
25	LOWER LEVEL RENOVATION										
26	LOWER LEVEL RENOVATION										
27	FIXTURE REPAIRS & REFINISH										
28	TRELLIS										
29	LOADING DOCK										
30	HALL RENOVATION - disposed during year										
31	FLOOR RENOVATION - disposed during year										
32	ROOM RENOVATION - disposed during year										
33	HALL RENOVATION - disposed during year										
34	ROOF REPAIRS										
35	ROOM RENOVATION										
36	TOTAL (lines 4 thru 35)										

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Maple Lawn Health Center# 0042424

Report Period Beginning:

01/01/2000 Ending: 12/31/2000**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ROOM RENOVATION		1992	793	79	10	79		680	9
10		DRAPERIES - disposed during year		1992	540	23	8	23		540	10
11		DECK		1992	2,574	257	10	257		2,122	11
12		ROOM RENOVATION		1992	1,067	107	10	107		926	12
13		LOBBY RENOVATION		1993	32,583	3,258	10	3,258		24,979	13
14		CENTRAL SUPPLY ROOM		1993	1,697	170	10	170		1,231	14
15		ADU CABINETS		1994	1,365	114	10	114		769	15
16		WALLPAPER		1994	776	97	12	97		622	16
17		WALLPAPER		1995	1,181	148	8	148		862	17
18		WALLPAPER		1995	194	24	8	24		132	18
19		CARPET ROOM 702		1995	203	25	8	25		130	19
20		WALLCOVERING ADMIN OFFICE		1995	732	92	8	92		475	20
21		CONFERENCE ROOM WING 2		1995	512	64	8	64		320	21
22		DINING ROOM RENOVATION		1996	4,706	588	8	588		2,695	22
23		LOBBY CARPET		1996	19,386	1,939	10	1,939		8,563	23
24		KITCHEN RAMP FLOORCOVERING		1996	526	66	8	66		286	24
25		BOILER REPAIRS		1996	1,440	144	10	144		612	25
26		ROOM RENOVATING		1996	969	121	8	121		484	26
27		ELEVATOR		1966	13,000		20			13,000	27
28		AIR CONDITIONING - disposed during year									28
29		Walk in Freezer		1975	2,853		10			2,853	29
30		Sprinkler Installation		1976	11,240		20			11,240	30
31		Sprinkler Installation		1977	743		20			743	31
32		Exit Alarm - disposed during year									32
33		Close Circuit Security System - disposed during year									33
34		Generator		1980	9,500	200	20	200		9,500	34
35		Narcotics Control Cabinet - disposed during year									35
36		TOTAL (lines 4 thru 35)			\$ 108,580	\$ 7,516		\$ 7,516	\$	\$ 83,764	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Fire Alarm - disposed during year									9
10		Lite Fixture Lobby	1982		4,634	232	20	232		4,287	10
11		Floor Covering Ramps Renovation	1982		1,116		10			1,116	11
12		Kitchen Air Vent	1982		650	33	20	33		594	12
13		Bathroom Floor Covering	1982		1,695		10			1,695	13
14		Floor Covering Lower Lobby	1983		1,296		10			1,296	14
15		Reworked Fire Alarm System	1983		1,146		10			1,146	15
16		Fire Alarm Extension	1983		900		10			900	16
17		Exhaust Fan	1984		2,800	140	20	140		2,322	17
18		Call Lights Restrooms	1985		2,195		8			2,195	18
19		ENTRANCE LOAD CONTROL	1985		13,672	380	15	380		13,671	19
20		LIGHT FIXTURES	1985		936		10			936	20
21		BED PAN WASHERS	1986		1,676		10			1,676	21
22		ENTRANCE FLOORING - disposed during year									22
23		WATER SOFTNER	1987		699		5			699	23
24		ALARM SYSTEM	1989		5,473	365	15	365		4,227	24
25		ELEVATOR MODERNIZATION	1989		4,600	230	20	230		2,645	25
26		WANDER GUARD SYSTEM	1990		7,685		8			7,685	26
27		DOOR ALARMS	1990		1,461		8			1,461	27
28		GARBAGE DISPOSAL	1990		951	87	10	87		951	28
29		AIR CONDITIONING CONDENSER	1990		2,395	160	15	160		1,625	29
30		AIR CONDITIONING UNIT	1991		3,105	155	20	155		1,475	30
31		MANAGEMENT SYSTEM (SUNITS)	1991		1,163	78	15	78		731	31
32		PRIVACY CURTAINS	1991		11,200	1,120	10	1,120		10,267	32
33		WATER HEATER TANKS	1992		12,622	841	15	841		7,432	33
34		BOILER WORK - disposed during year									34
35		Century Whirlpool Tub	1993		3,284	219	15	219		1,697	35
36		TOTAL (lines 4 thru 35)			\$ 87,354	\$ 4,040		\$ 4,040	\$	\$ 72,729	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		LAUNDRY MACHINE MOTOR	1993		515	51	10	51		381	9
10		ASSEMBLY ROOM SOUND SYSTEM	1993		1,410	94	15	94		689	10
11		WANDER GUARD DOOR MONITOR	1993		1,212	152	8	152		1,100	11
12		MTC TELEPHONE SYSTEM	1993		10,769	1,077	10	1,077		7,718	12
13		PAGING SYSTEM	1994		707		3			707	13
14		ADU DOOR MONITORING SYSTEM	1994		914		3			914	14
15		UPGRADE OF ELEVATOR	1994		3,298	330	10	330		2,144	15
16		AIR CONDITIONING-DINING ROOM	1994		1,723	86	20	86		545	16
17		ALPHA SENCE SYSTEM	1994		484		5			484	17
18		HATCO TOASTER	1995		980	98	10	98		572	18
19		FIBER OPTICS WIRING	1995		4,645	232	5	232		4,645	19
20		DINING ROOM A/C UNIT	1995		3,187	159	20	159		902	20
21		WOOD GRAPHICS SIGNS	1995		1,131	162	7	162		903	21
22		30 SMOKE DETECTORS	1995		3,030	379	8	379		2,021	22
23		KITCHEN SHELVES / COUNTER	1995		6,667	444	15	444		2,318	23
24		PARKER BATH	1995		8,598	860	10	860		4,371	24
25		MAGNETIC DOOR LOCK SYSTEM	1996		2,846	284	10	284		1,374	25
26		SERVICE SINK	1996		656	66	10	66		318	26
27		NURSE CALL SYSTEM	1996		21,777	2,178	10	2,178		8,893	27
28		A/C UNIT CENTRAL SUPPLY ROOM	1996		3,515	352	10	352		1,642	28
29		ELEVATOR UPGRADE	1996		13,117	1,312	10	1,312		6,122	29
30		A/C UNIT LAUNDRY ROOM	1996		5,986	599	10	599		2,795	30
31		A/C UNIT KITCHEN	1996		5,688	569	10	569		2,607	31
32		ALARM SYSTEM	1996		709	89	8	89		385	32
33		COMPUTER WIRING FOR LAUNDRY ROOM	1996		727	145	5	145		617	33
34		TEKTONE DOOR ALARM	1996		673	84	8	84		343	34
35		VERTICAL BLINDS	1994		1,021	128	8	128		778	35
36		TOTAL (lines 4 thru 35)			\$ 105,985	\$ 9,930		\$ 9,930	\$	\$ 56,288	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		LANDSCAPING	1997		3,116	311	10	311		1,141	9
10		REMODEL SMOKING AREA	1997		553	55	10	55		206	10
11		PATIENT ROOM RENOVATION	1997		979	122	8	122		448	11
12		LOBBY RENOVATION	1997		499	55	9	55		216	12
13		SINK & COUNTER FOR EMPLOYEE LOUNGE	1997		1,319	165	8	165		632	13
14		FIREPLACE CONVERSION	1997		2,762	276	10	276		1,012	14
15		KITCHEN WATERLINE REPLACEMENT	1997		1,591	159	10	159		503	15
16		CHAPEL RENOVATION	1997		17,045	1,705	10	1,705		5,115	16
17		NURSE CALL SYSTEM CORDS	1997		588	118	5	118		461	17
18		ADDRESSABLE FIRE ALARM SYSTEM	1997		11,790	1,179	10	1,179		4,618	18
19		FIRE ALARM ANNUNCIATOR	1997		985	98	10	98		361	19
20		EXPANSION TANK	1997		3,800	475	8	475		1,742	20
21		DOOR SECURITY UPGRADE	1997		2,843	284	10	284		1,042	21
22		PHONE SYSTEM ADDITIONS	1997		821	82	10	82		246	22
23		BATHTUB	1997		6,080	608	10	608		1,824	23
24		BATH LIFT	1997		3,294	329	10	329		987	24
25		PARKING LOT REPAIR	1998		1,829	183	10	183		396	25
26		LANDSCAPING	1998		700	70	10	70		169	26
27		BOILER REPAIRS	1998		2,415	242	10	242		705	27
28		AUTOMATIC DOOR	1998		3,651	365	10	365		973	28
29		WING 3 RENOVATION	1998		2,825	283	10	283		613	29
30		DINING ROOM RENOVATION	1998		13,665	1,367	10	1,367		2,734	30
31		HALL 3 FIRE DETECTORS	1998		1,794	224	8	224		616	31
32		HALL 2 FIRE DETECTORS	1998		2,994	374	8	374		998	32
33		EMERGENCY GENERATOR REPAIRS	1998		1,356	136	10	136		351	33
34		FREE STANDING BATH	1998		8,958	896	10	896		2,090	34
35		SECURITY SYSTEM/AUD OUTDOOR GATE	1998		1,127	141	8	141		305	35
36		TOTAL (lines 4 thru 35)			\$ 99,379	\$ 10,302		\$ 10,302	\$	\$ 30,504	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
9		CABLE SYSTEM		1998	24,353	4,871	5	4,871		9,742	9
10		A/C LOWER LOBBY / BY DINING ROOM		1998	3,604	360	10	360		720	10
11		ASPHALT REPAIR		1999	2,467	247	10	247		329	11
12		DINING ROOM RENOVATION		1999	1,428	143	10	143		250	12
13		HALL 6 RENOVATION		1999	2,588	259	10	259		345	13
14		NEW DOOR FOR ENTRANCE		1999	2,665	267	10	267		311	14
15		HALL 7 RENOVATION		1999	6,647	665	10	665		720	15
16		BATH FLOORING		1999	2,018	252	8	252		273	16
17		JANITOR FLOOR		1999	326	41	8	41		44	17
18		HALL 1 RENOVATION		1999	2,276	285	8	285		308	18
19		ELECTRONIC EYE DOOR MAIN ENTRANCE		1999	3,723	372	10	372		372	19
20		OFFICE RENOVATION		1999	2,458	246	10	246		246	20
21		LOUNGE RENOVATION		1999	927	93	10	93		93	21
22		DOOR ALARMS HALLS 1 & 3		1999	4,285	536	8	536		1,072	22
23		FIRE ALARMS HALLS 1, 6, 7		1999	5,290	661	8	661		1,157	23
24		A/C CONDENSOR		1999	1,001	100	10	100		150	24
25		ADJUSTABLE SINK		1999	2,569	321	10	321		321	25
26		CAROUSEL WHIRLPOOL		1999	16,897	1,690	10	1,690		1,690	26
27		HEATING A/C UNIT HALL 6		1999	998	100	10	100		100	27
28		AIR CONDITIONING COMPRESSOR - disposed during year									28
29		ASPHALT REPAIR		2000	2,352	59	10	59		59	29
30		TEMPERED WATER SYSTEM REDESIGNED		2000	14,400	480	20	480		480	30
31		RENOVATE SOCIAL SERVICE OFFICE		2000	3,422	200	10	200		200	31
32		WANDERGUARD MONITORS		2000	2,591	229	8	229		229	32
33		NEW BOILER IN CLEVELAND STEAMER		2000	4,076	102	10	102		102	33
34		OCTEL 100 VOICEMAIL SYSTEM		2000	6,260	306	5	306		306	34
35		CABLE SYSTEM EXPANSION		2000	1,844	31	5	31		31	35
36		TOTAL (lines 4 thru 35)			\$ 121,465	\$ 12,916		\$ 12,916	\$ 0	\$ 19,650	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center

STATE OF ILLINOIS

0042424

Report Period Beginning:

01/01/2000 Ending: 12/31/2000

Page 12F

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10	DRAPERIES - disposed during year				(540)					(540)	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18	Allocation from Management Company							13,136	13,136		18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ (540)	\$ 0		\$ 13,136	\$ 13,136	\$ (540)	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 331,007	\$ 35,833	\$ 35,833		Various	\$ 156,407	37
38	Current Year Purchases	31,398	2,867	2,867		Various	2,867	38
39	Fully Depreciated Assets	84,298					84,298	39
40	Allocation from Management Company			23,384	23,384			40
41	TOTALS	\$ 446,703	\$ 38,700	\$ 62,084	\$ 23,384		\$ 243,572	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,012,450	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 155,869	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 192,389	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 36,520	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,803,937	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Work in Progress	\$ 249,364	58
59			59
60			60
61		\$ 249,364	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ N/A Description:

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18		<u>N/A</u>			18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>80</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 250	\$	\$ 250
2	Books and Supplies		1,829		1,829
3	Classroom Wages (a)		16,221		16,221
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,255		1,255
9	TOTALS	\$	\$ 19,555	\$	\$ 19,555
10	SUM OF line 9, col. 1 and 2 (e)	\$	19,555		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ 1,050

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	22
2. From other facilities (f)	5
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	27

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a, C3	hrs	\$	945	\$ 43,192	\$	945	\$ 43,192	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		173	10,924		173	10,924	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3,2	hrs		1,491	67,462	620	1,491	68,082	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				22,229		22,229	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule 16A					3,524			3,524	13
14	TOTAL			\$	2,609	\$ 125,102	\$ 22,849	2,609	\$ 147,951	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 114,082	\$ 114,082	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 28,081)	455,173	455,173	3
4	Supply Inventory (priced at cost)	45,466	45,466	4
5	Short-Term Investments			5
6	Prepaid Insurance	8,128	8,128	6
7	Other Prepaid Expenses	1,697	1,697	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attached Schedule 17A	3,585	3,585	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 628,131	\$ 628,131	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	469,050	469,050	12
13	Land	2,386	2,386	13
14	Buildings, at Historical Cost	3,102,905	3,059,317	14
15	Leasehold Improvements, at Historical Cost	504,423	504,044	15
16	Equipment, at Historical Cost	425,994	446,703	16
17	Accumulated Depreciation (book methods)	(1,815,022)	(1,803,937)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Work in Progress	249,364	249,364	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,939,100	\$ 2,926,927	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,567,231	\$ 3,555,058	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,649	\$ 75,649	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	163,295	163,295	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,771	12,771	31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,958	2,958	32
33	Accrued Interest Payable	7,145	7,145	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	31,933	31,933	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 293,751	\$ 293,751	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,527,327	1,527,327	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,527,327	\$ 1,527,327	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,821,078	\$ 1,821,078	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,746,153	\$ 1,733,980	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,567,231	\$ 3,555,058	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,677,867	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,677,867	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	68,286	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 68,286	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,746,153	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Maple Lawn Health Center

0042424

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,675,418	1
2	Discounts and Allowances for all Levels	(582,657)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,092,761	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	250,772	6
7	Oxygen	16,274	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 267,046	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,657	13
14	Non-Patient Meals	65,070	14
15	Telephone, Television and Radio	12,188	15
16	Rental of Facility Space		16
17	Sale of Drugs	18,491	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,568	19
20	Radiology and X-Ray	420	20
21	Other Medical Services	158,194	21
22	Laundry	533	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 262,121	23
D. Non-Operating Revenue			
24	Contributions	92,948	24
25	Interest and Other Investment Income***	51,943	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 144,891	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule 19A	7,064	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,064	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,773,883	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,015,659	31
32	Health Care	2,212,488	32
33	General Administration	1,070,666	33
B. Capital Expense			
34	Ownership	257,372	34
C. Ancillary Expense			
35	Special Cost Centers	100,550	35
36	Provider Participation Fee	48,862	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,705,597	40
41	Income before Income Taxes (line 30 minus line 40)**	68,286	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 68,286	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a division of a not-for-profit organization.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Maple Lawn Health Center**# **0042424**Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,935	2,131	\$ 41,248	\$ 19.36	1
2	Assistant Director of Nursing	1,788	2,080	38,498	18.51	2
3	Registered Nurses	11,430	12,319	236,946	19.23	3
4	Licensed Practical Nurses	19,866	21,765	339,340	15.59	4
5	Nurse Aides & Orderlies	82,614	89,459	970,822	10.85	5
6	Nurse Aide Trainees	1,429	1,520	16,221	10.67	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,326	3,961	42,019	10.61	8
9	Activity Director	1,780	2,080	24,336	11.70	9
10	Activity Assistants	4,330	4,586	35,445	7.73	10
11	Social Service Workers	4,769	5,440	55,519	10.21	11
12	Dietician					12
13	Food Service Supervisor	3,848	4,200	52,664	12.54	13
14	Head Cook	6,199	6,722	51,640	7.68	14
15	Cook Helpers/Assistants	14,773	16,118	128,547	7.98	15
16	Dishwashers					16
17	Maintenance Workers	5,663	6,233	72,473	11.63	17
18	Housekeepers	13,489	14,843	112,580	7.58	18
19	Laundry	6,981	7,682	55,816	7.27	19
20	Administrator	1,872	2,080	54,189	26.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,670	6,060	53,129	8.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(See Sch. 20A)	2,967	3,200	33,997	10.62	32
33	Other(specify) See Sch. 20A	13,315	14,733	248,549	16.87	33
34	TOTAL (lines 1 - 33)	208,044	227,212	\$ 2,663,978 *	\$ 11.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	193	\$ 6,720	L1, C3	35
36	Medical Director	Monthly	1,800	L9, C3	36
37	Medical Records Consultant	Monthly	640	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,650	L10, C3	39
40	Physical Therapy Consultant	172	7,727	L10a, C3	40
41	Occupational Therapy Consultant	244	10,057	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	172	L11, C3	44
45	Social Service Consultant	13	678	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	626	\$ 29,444		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	108	\$ 3,209	L10, C3	50
51	Licensed Practical Nurses	430	11,561	L10, C3	51
52	Nurse Aides	3,347	54,214	L10, C3	52
53	TOTAL (lines 50 - 52)	3,885	\$ 68,984		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Steve Evans	Administrator	0.00%	\$ 54,189	Workers' Compensation Insurance		\$ 65,136	IDPH License Fee		\$		
				Unemployment Compensation Insurance			Advertising: Employee Recruitment		4,201		
				FICA Taxes		179,896	Health Care Worker Background Check		752		
				Employee Health Insurance		142,788	(Indicate # of checks performed 63)				
				Employee Meals			Miscellaneous Licenses		110		
				Illinois Municipal Retirement Fund (IMRF)*			Mennonite Health Services		9,737		
				Employee Physical		911	Life Services Network		4,645		
				Annuity Plan 403B		50,577	Miscellaneous Dues		340		
				Sick Pay		15,133	Miscellaneous Subscriptions		213		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 54,189	Group Life Insurance		4,997	Allocation from Management Company		1,390	
B. Administrative - Other					Employee Appreciation		547	Less: Public Relations Expense		()	
Description				Amount	Allocation from Management Company		71,197	Non-allowable advertising		()	
Phone Fee (MLH)	(Eliminated in Column 7)	\$ 504	Other Employee Benefits		7,931	Yellow page advertising		()			
Administrative Fee (MLH)	(Eliminated in Column 7)	102,050	TOTAL (agree to Schedule V, line 22, col.8)		\$ 539,113	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,388			
Chaplain Fee (MLH)	(Eliminated in Column 7)	(1,763)	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**					
Human Resource Fee(MLH)	(Eliminated in Column 7)	27,321	Description		Line #	Amount	Description	Amount			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 128,112		\$	Out-of-State Travel	\$			
C. Professional Services											
Vendor/Payee	Type	Amount									
Heinold- Banwart Ltd.	Accounting	\$ 9,300									
American Express Tax & Bus. Svc.	Consulting	733									
Altschuler, Melvoin & Glasser LLP	Accounting	7,550									
Leiken & Lankton LLC	Legal	238									
Small Parker & Blossom	Section125 Administrators	1,771									
Lincoln Life	Section125 Administrators	86									
					</						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maple Lawn Health Center

STATE OF ILLINOIS

0042424

Report Period Beginning: 01/01/2000

Page 23

Ending: 12/31/2000

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - \$4645
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5.52 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 64,039 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 48,862
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 65,070
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 26%
d. Have vehicle usage logs been maintained? Adequate Records are maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinold-Banwart, Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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